

Polymyalgia Rheumatica

Background:

An inflammatory, likely autoimmune, state affecting the elderly which leads to proximal muscular pain and weakness. The true etiology is unknown at this time but thought due to immune triggering of a genetically predisposed individual by an environmental cause (ie virus or other antigen)

Epidemiology:

More common in Northern European descent

More common over 50 years old

Median age of onset 72

Incidence 52 cases per 100,000 over 50 yo (varies a lot by country and latitude)

Prevalence 0.5%

Clinical Description and Diagnosis

1. Pain and Weakness of hips and shoulders, but also can affect knees, MCPs, and other synovial tissues and bursae

2. >1 hours morning stiffness

3. Elevated inflammatory markers

4. Rapid response to steroids at low dose

Can have low-grade temperature

There are multiple diagnostic scoring structures which mostly use the above criteria

Labs: ESR, CRP, CBC, LFTs, TSH, Calcium, CK and Lytes

Pathology:

Macrophage and T-cell activated inflammation of bursa and certain layers of arteries

Pearls:

50% with GCA (Giant Cell Arteritis) have PMR

15% with PMR have GCA

Taper steroids slowly due to high risk of relapse

Long-term steroid risks must be discussed

Can present as carpal tunnel

Prognosis:

Generally limited with 2-3 year course with use of steroids

Treatment:

Excellent response to prednisone

Start 15-20 mg (no standard dose or taper) and taper to 10mg, then 1-2 mg taper per month

+++Researched using emedicine and UTD articles on PMR and discussion with Dr. Stone.